MEDPAC Medicare Payment Advisory Commission

MEETING BRIEF

October 6-7, 2005

Improving payment for clinical laboratory services

ISSUE: Spending for clinical lab services has increased considerably in the recent past. Since 1999, volume growth has caused Medicare expenditures for lab services to climb an average of 10 percent per year. Growth in spending for lab services raises several questions for Medicare. What is the program buying for these increased expenditures? Does Medicare's payment methodology promote efficiency?

KEY POINTS: Medicare pays labs directly based on a fee schedule for tests performed in outpatient settings: hospital-based labs, independent labs, and physician labs. To pay for clinical lab services, Medicare uses carrier-specific fee schedules. Payment rates were initially set separately for more than 1000 tests in each carrier's geographic market, based on what local labs charged in 1983; since then, the rates have been updated periodically for inflation. National payments limits are set at 74 percent of the median of all carrier fee schedule amounts for each service. In practice, most lab claims are paid at the national limits.

At this meeting, staff will present background information about clinical lab services, including Medicare's coverage and payment policies and CMS's competitive bidding demonstration. Future work plans will be discussed.

ACTION: Staff seeks Commissioner input on future work in this area.

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